STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Human Services
DIVISION OF HEALTH CARE QUALITY,
FINANCING AND PURCHASING
Center For Child and Family Health
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Cranston, Rhode Island 02920
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RIte Care

MEMORANDUM

September 13, 2005

TO: Patrice Cooper (UHC)
Gilson DaSilva (BCBS)
Ron Barnett (NHPRI)

CC: Murray Brown, Lissa DiMauro, Tricia Leddy, Rick Jacobsen, Janine Zuromski

FROM: Deborah Florio
Administrator, Family and Children's Services

SUBJECT: Benefit Clarification: Mifepristone (RU-486) Coverage Criteria

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Mifepristone, formerly known as RU-486, is FDA-approved for the non-surgical termination of early pregnancies. As it is an abortifactant, it is a covered service for comprehensive RIte Care only when it meets Medical Assistance (MA) abortion criteria.

In Attachment F of the January 1, 2005 RIte Care contract, Mifepristone was identified as a covered Family Planning Benefit. The Family Planning benefit does not cover surgical or Mifepristone-induced abortions.

The Rhode Island Medical Assistance policy on reimbursement for abortion is based upon the signed physician's "Certification Statement" that the abortion was performed to terminate pregnancy resulting from rape or incest, or to save the life of the mother. This policy applies to surgical or Mifepristone-induced abortions (RIte Care contract Attachment C).

The Rhode Island Medical Assistance policy for sterilization, hysterectomy, and abortion procedures, as printed in the *Physician Services Provider Reference Manual*, is attached for your reference and may be accessed at:
http://www.dhs.ri.gov/dhs/heacre/provsvcs//manuals/physicians/phytoc.htm.

Should you require further information regarding RIte Care coverage for Mifepristone, please contact Janine Zuromski at (401) 462-2489.

Attachment

SERVICES REQUIRING ADHERENCE TO FEDERAL GUIDELINES

This policy section lists the Federally mandated guidelines and billing requirements for sterilization, hysterectomy and abortion procedures. These guidelines must be adhered to in order to receive reimbursement from the Medical Assistance program for these services. Detailed instructions for completing required forms, including examples of the forms, are outlined in this section.

ABORTION REVIEW GUIDELINES

1. In accordance with Public Law 103-112, revision to the Hyde Amendment, the Rhode Island Department of Human Services (DHS) implemented the federal directive pertaining to Medicaid reimbursement for abortions. For dates of service on or after October 1, 1993, abortions may be performed for pregnancies resulting from rape, incest or as a result of life-threatening conditions of the mother.

2. Reimbursement of abortions is based on the physician's "Certification Statement" that the abortion was performed to save the life of the mother, to terminate pregnancy resulting from rape or to terminate pregnancy resulting from incest.

3. Listed below are the physician certification statement's that must accompany all claims for abortions for federal compliance and proper reimbursement. One of these statements with the EXACT wording must be signed by the physician for an abortion to be paid. Substitute wording will not be acceptable.

"I, (Physician's Name) certify that on behalf of my professional judgment, the procedure performed was necessary to save the life of the mother, (Recipient's full name and Medicaid number) of (Recipient's complete address)."

_____
Physician's Signature

"I, (Physician's Name) certify that on behalf of my professional judgment, the procedure performed on , (Recipient's full name and Medicaid number) of (Recipient's complete address) was necessary to terminate a pregnancy that was the result of rape. I have counseled the recipient concerning the availability of health and social support services and the importance of reporting the rape to the appropriate law enforcement authorities."

_____
Physician's Signature

"I, (Physician's Name) certify that on behalf of my professional judgment, the procedure performed on, (Recipient's full name and Medicaid number) of (Recipient's complete address) was necessary to terminate a pregnancy that was the result of incest. I have counseled the recipient concerning the availability of health and social support services and the importance of reporting the incest to the appropriate law enforcement authorities."

_____
Physician's Signature

The signature of the physician must be original script, NOT typed or rubber stamped.

4. A copy of the signed certification statement must be submitted with each claim for reimbursement to be considered.

5. The following diagnoses are payable if present on the claim:

179	57522	62530	6338	63460	66624
180	5981	626	6339	6347	6663
1800	5985	6262	634	63470	666700
1801	615	62620	63401	6348	667
1808	6151	6266	6341	63480	6670
1809	6159	62660	6341	6349	6671
2180	616	627	63410	63490	66714
2181	617	6270	63411	63491	670
2182	621	62700	6342	63791	6700
2189	6210	631	63420	6564	67000
219	6211	6310	6343	65640	67004
2331	6212	63100	63430	65643	795
2332	6213	632	6344	666	79500
236	622	633	63440	6660	V2710
2360	6227	6330	6345	66600	V2740
36410	62270	6331	63450	6661	V2770
5752	6253	6332	6346	6662	

6. Claims billed with other than the approved diagnoses above will suspend for review.

- If the surgical procedure billed is a suspect abortion, claim is denied. An operative report, history & physical and pathology report are requested.
- D&C's for incomplete or missed abortion is payable and should be coded appropriately.
- D&C's for therapeutic or diagnostic purposes which is deemed medically necessary is payable and should be coded 58120.

HYSTERECTOMY ACKNOWLEDGMENT CONSENT FORM

1. For hysterectomies, the appropriate acknowledgment consent form must be completed with the required signatures. The date of the signature may be the date of surgery, providing the form was signed prior to the surgery being performed.

2. Hysterectomy acknowledgment consent forms are not required when the performing physician certifies and places his or her signature on the claim form or attachment that at least one of the following circumstances existed prior to surgery:

   Patient already sterile prior to the hysterectomy and the cause of the sterility is stated, such as congenital disorder or previously sterilized.

   Patient requires emergency hysterectomy because of a life-threatening situation. The physician must state the nature of the emergency and certify that he or she determined that prior acknowledgment was not possible. Since the acknowledgment may be signed the day of surgery, an emergency situation requires the patient be unconscious or under sedation and unable to sign the acknowledgment.

   The document must indicate the lack of patient signature on the Medical Assistance Hysterectomy Statement.

3. Hysterectomy acknowledgment consent forms with missing or incomplete signatures will be denied with the following message: "Consent Form Missing Or Invalid."

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
RHODE ISLAND MEDICAL ASSISTANCE PROGRAM

600 New London Avenue
Cranston, Rhode Island 02920

MEDICAL ASSISTANCE HYSTERECTOMY STATEMENT

EXPLANATION OF HYSTERECTOMY PROCEDURE

A hysterectomy means a medical procedure or operation for the purpose of removing the uterus. A result of this operation will render the individual permanently sterile.

ACKNOWLEDGEMENT

I acknowledge that I have been informed that the hysterectomy procedure I am to undergo is being performed for medical reasons other than sterilization. I understand, however, that I will be permanently incapable of becoming pregnant or bearing children. This information has been provided to me orally and in writing.

Signed _____
Patient — Date of Signature

_____
Parent/Guardian/Relative (if indicated) — Date of Signature

_____
Physician — Date of Signature

ROUTING INSTRUCTIONS

This statement must be completed and forwarded to the hospital in which the operation is to be performed prior to the date of admission. The hospital will then submit this statement together with the Medical Assistance hospital billing form and the P.S.R.O. certification form to the Rhode Island Medical Assistance Program. A signed copy must also be provided to the patient. In addition, it is suggested that the physician should retain a signed copy for his files.

MAHS-1 5/87

MEDICAL ASST. PROGRAM

Hysterectomy Consent Form

STERILIZATION PROCEDURES

Payment of elective sterilizations is NOT made if the recipient meets any of the following criteria:

1. Under 21 years of age at the time the consent form is signed.
2. Has been declared mentally incompetent for the purpose of sterilization (recipients are presumed to be mentally competent unless adjudicated incompetent for the purpose of sterilization).
3. Is institutionalized in a correctional facility, mental hospital or other rehabilitative facility.
4. Gave consent in labor or childbirth, under the influence of alcohol or other drugs, or while seeking or obtaining an abortion.
5. A valid consent form is missing.

II. CONSENT FORM

A. Who Can Submit

- Physician
- Hospital
- Anesthesiologist

Hospitals may submit a copy of the consent form; however, surgeons are encouraged to submit the original if possible. In any case, the first consent form received by EDS will be evaluated to determine if the form is valid.

B. What Is A Valid Consent Form

1. Typewritten, blocked or facsimile stamped signatures are NOT acceptable for signature requirements.

2. All blanks should be completed unless otherwise specified. **Effective May 19, 1995, if consent forms are not readable, claims will be denied.**

3. All state-required and federally-required fields must be completed: (Fields 1-8, 11-16, 18). If required fields are left blank, the consent form is not valid and claims must be denied with a message stating "Missing or Incomplete Consent Form."

4. Any optional field may be left blank: (Fields 9-10, 17) unless indicated as applicable and identified below.

5. If a valid consent form is submitted by either a surgeon, hospital or anesthesiologist, all claims can be paid if all other Medicaid requirements such as Medicaid eligibility are met.

6. An interpreter must be provided if the consent form is not written in the language of the individual to be sterilized or the person obtaining consent does not speak the language of the individual. If an interpreter is used, the "Interpreter's Statement" must be completed.

7. The "Statement of the Person Obtaining Consent" must be completed by the person who explains the surgery and its implications, alternate methods of birth control, and the fact that the consent may be withdrawn at any time. The signature of the person obtaining consent must be completed at the time the consent is obtained. This must be an original signature, NOT a rubber stamp.

8. The physician or the person obtaining consent must allow a witness of the recipient's choice (if desired) when the consent is signed and/or arrangements must be made for handicapped individuals.

9. The "Physician's Statement" must be completed. The physician must indicate that 30 days or 72 hours have passed between consent and surgery by crossing out paragraph #1 or #2 as indicated on the consent form.

10. The "Physician's Statement" must be signed and dated on or after the day of surgery in all circumstances. This must be an original signature, **not** a rubber stamp.

11. When a sterilization is performed at the time of a premature delivery, the expected date of delivery must be recorded in Fjeld 17. The time of the recipient's consent must be at least 72 hours prior to the actual delivery and 30 days prior to the expected date of delivery

12. When a sterilization is performed at the time of emergency abdominal surgery, the circumstances must be described in the appropriate area in Field 17. The time of the recipient's consent must be at least 72 hours prior to the surgery and 30 days prior to the expected date of delivery. If additional space is required, documentation may be attached to the consent form.

13. The physician must review the consent form with the recipient shortly before the surgery.

14. The actual sterilization procedure performed must be identical to that for which the recipient gave informed, written consent. Each reference to the sterilization procedure on the consent form and the claim form must be identical.

15. The consent form is valid for 180 days from the date of the recipient's signature.

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES
MEDICAL ASSISTANCE PROGRAM
PHYSICIAN SERVICES

VERIFICATION GUIDELINES FOR STERILIZATION CONSENT FORMS

Field #

Consent to Sterilization

1. Doctor's Name Providing Information. Must be completed. If blank, denied as incomplete form.

2. Name of Sterilization Procedure. Blank field is not acceptable. If blank, denied as incomplete form. Procedures must match. Initials such as "TL" (Tubal Ligation) or "BTL" (Bilateral Tubal Ligation) may be used.

3. Recipient's Date of Birth. Blank field is not acceptable. Acceptable partial dates are: Month and Year Only, Month and Day Only if it is clear that the recipient was 21 years of age when the consent to sterilization was signed. If not or field is blank, denied as incomplete form.

4. Recipient Name. First or Last names must be completed. If blank or first or last name only, denied as incomplete form.

5. Doctor/Clinic. Blank field is not acceptable. Examples of acceptable information are: The name of the physician performing the sterilization, the name of the doctor/hospital clinic, or "Resident" of a specified clinic.

6. Method of Sterilization. Blank field is not acceptable. The procedures must match.

7. Recipient Signature. Blank field is not acceptable. If a recipient is unable to sign and must enter a mark "X", one of the other signers should write out the recipient's full name, placing their own initials by the recipient's mark.

8. Date of Recipient's Signature. Blank or incomplete date is not acceptable. Time is not required unless the mandatory 30 day waiting period cannot be verified.

9. Race and Ethnicity. Optional, not denied if blank

Interpreter's Statement

10. Interpreter's Statement. If Interpreter is used, must be completed, signed and dated on or after the date the Consent to Sterilization and Statement of Person Obtaining Consent were signed and dated.

Statement of Person Obtaining Consent

11. Recipient Name. Blank field is not acceptable. If blank, denied as incomplete form.

12. Name of Sterilization Procedure. Blank field is not acceptable. If blank, denied as incomplete form. The procedures must match.

13. Signature of Person Obtaining Consent. Blank field is not acceptable. If blank, denied as incomplete form.
    Typewritten or printed signatures are not acceptable.
    Rubber Stamps are not acceptable
    Facility Name and Address must be completed. If either is blank, denied as incomplete form.

Physician's Statement

14. Recipient Name. Blank field is not acceptable. If blank, denied as incomplete form.

15. Date of Sterilization Procedure. Blank field is not acceptable. If blank, denied as incomplete form.

16. Name of Sterilization Procedure. Blank field is not acceptable. If blank, denied as incomplete form. The procedures must match.

17. Expected Date of Delivery. When a sterilization is performed at the time of a premature delivery, the expected date of delivery is required. The time of the recipient's consent must be at least 72 hours prior to the actual delivery and 30 days prior to the expected date of delivery.

    When a sterilization is performed at the time of emergency abdominal surgery, the circumstances must be described in the appropriate area in Field 17. The time of the recipient's consent must be at least 72 hours prior to the surgery and 30 days prior to the expected date of delivery. If additional space is required, documentation may be attached to the consent form. An emergency C-Section is not considered emergency abdominal surgery without documentation of emergency circumstances. If documentation is not present, denied for more information.

18. Physician's Signature. Blank field is not acceptable. If blank, denied as incomplete form. Typewritten or printed signatures are not acceptable. Rubber Stamps are not acceptable

19. Date of Physician's Signature. Blank field is not acceptable. If blank, denied as incomplete form. The physician statement can be signed on or after the day of surgery.